



# Children's Mental Health Waiver

## Family Care Team Member Assessment Report

Name of Youth: \_\_\_\_\_

Date of Individual Service Meeting: \_\_\_\_\_

Date of Assessment/Evaluation: \_\_\_\_\_

Assessment Tools used: \_\_\_\_\_ ☐ N/A

Representing Child Serving Agency: \_\_\_\_\_

### **Child/Youth Strengths**

What does the child/youth do well?

What are his/her favorite things to do?

What are the things he/she likes the most in the environment being assessed?

What aspects of the child/youth's life are working for him/her?

### **Areas of Concern**

What aspects of the child/youth's life are difficult for him/her?

What has been tried and found to work or not work?

What supports does he/she receive or use in these situations?

What are the primary health and safety concerns for this child/youth?

**Provider Recommendations**

*(related to a focus for training, a behavior support plan, safety intervention, other)*

**Additional Information:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date